



# WebRD

8343 Roswell Road, Suite 323  
Atlanta, GA 30350  
404.414.1112  
support@Web-RD.com

## One-on-One Personalized Coaching Assessment Form

Referred by \_\_\_\_\_ Date \_\_\_\_\_

*To be filled out by the Client*

Client's Name \_\_\_\_\_ Parent's Name (if client is a minor) \_\_\_\_\_

Date of birth \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ SSN \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

Email Address \_\_\_\_\_

Occupation/Employer \_\_\_\_\_ Work hours \_\_\_\_\_

Marital Status: Single Married Divorced Separated Widowed

Number of persons in household Adults \_\_\_\_\_ Children \_\_\_\_\_

**PLEASE FILL OUT COMPLETELY and RETURN WITH PHOTO COPY OF HEALTH CARD**

Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Policy # \_\_\_\_\_

Subscriber's Name and Date of Birth \_\_\_\_\_

Subscriber's SSN \_\_\_\_\_

Employer of Subscriber \_\_\_\_\_

Relationship to Subscriber \_\_\_\_\_

Primary Physician \_\_\_\_\_ Date of last checkup \_\_\_\_\_

Reason for referral to this office? \_\_\_\_\_

How long have you had this condition/disease? \_\_\_\_\_

Under other physician's care? Y N If so, who and for what? \_\_\_\_\_

**Personal Medical History: Check conditions that apply**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Heart disease or stroke | <input type="checkbox"/> Food allergies             | <input type="checkbox"/> Anemia             |
| <input type="checkbox"/> High blood pressure     | <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Depression         |
| <input type="checkbox"/> Hyperlipidemia          | <input type="checkbox"/> Obesity                    | <input type="checkbox"/> Major surgery      |
| <input type="checkbox"/> Thyroid/other           | <input type="checkbox"/> Arthritis                  | <input type="checkbox"/> Hypoglycemia       |
| <input type="checkbox"/> Hormone conditions      | <input type="checkbox"/> Dentures                   | <input type="checkbox"/> Indigestion        |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Chewing problems           | <input type="checkbox"/> Physical handicaps |
| <input type="checkbox"/> Lung problems           | <input type="checkbox"/> Constipation               | <input type="checkbox"/> Surgeries          |
| <input type="checkbox"/> Food sensitivities      | <input type="checkbox"/> Diarrhea                   | <input type="checkbox"/> Other              |
| <input type="checkbox"/> Ulcers                  | <input type="checkbox"/> Other allergies            |   |
|  | <input type="checkbox"/> Gastrointestinal disorders |   |

**Family Medical History: Check conditions that apply**

- |  |   |
|--|---|
| <input type="checkbox"/> Heart disease or stroke | <input type="checkbox"/> Food allergies   |
| <input type="checkbox"/> High blood pressure     | <input type="checkbox"/> Diabetes         |
| <input type="checkbox"/> Hyperlipidemia          | <input type="checkbox"/> Obesity          |
| <input type="checkbox"/> Thyroid/other Hormone   | <input type="checkbox"/> Arthritis        |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Gallbladder      |
| <input type="checkbox"/> Lung problems           | <input type="checkbox"/> Gastrointestinal |
| <input type="checkbox"/> Food sensitivities      | <input type="checkbox"/> Other            |
| <input type="checkbox"/> Other                   |   |

List all medications you are taking <i>Use the back if you need more space</i>	Time of Day	Amount	Purpose

Reactions to any medications \_\_\_\_\_

Alcohol intake: # drinks per day \_\_\_\_\_ per week \_\_\_\_\_

Type of alcohol \_\_\_\_\_

Tobacco usage: smoker      non smoker      quit smoking \_\_\_\_\_ years ago

Chewing tobacco: Y N

Height \_\_\_\_\_ Present Weight \_\_\_\_\_ Usual Weight \_\_\_\_\_ Highest Weight \_\_\_\_\_

Goal Weight \_\_\_\_\_ Pounds gained this year \_\_\_\_\_ Pounds lost this year \_\_\_\_\_

Is anyone in your family overweight?    Y    N    If so, who? \_\_\_\_\_

\_\_\_\_\_

*To be filled out by the Client*

*For dietitian use only*

<p><b>Have you ever taken diet pills?</b> Y N</p> <p><b>Have you ever been on a special diet before?</b> Y N</p> <p><b>If yes, what type and when?</b> _____ _____</p> <p><b>Did you stay on the diet?</b> Y N</p> <p><b>List any problems you had with the diet?</b> _____ _____</p> <p><b>Have you ever seen a registered dietitian before?</b> Y N</p> <p><b>Is so, where?</b> _____</p> <p><b>List any vitamins/minerals or any other kinds of supplements you are taking.</b> _____ _____</p>	<p><b>Diet History:</b></p> <p><b>Supplements:</b></p>
<p><b>Anyone else in the household on special foods/diets?</b> Y N</p> <p><b>If so, what type of foods/diets?</b> _____</p> <p><b>Who cooks meals?</b> _____</p> <p><b>Who does the grocery shopping?</b> _____</p> <p><b>Out of 21 meals/week, what % is prepared at home?</b> _____</p> <p><b>How are most foods prepared at home?</b> Baked Boiled Fried Other</p> <p><b>How often do you go out to eat per week including carryout or delivery?</b> _____</p> <p><b>What restaurants do you frequent?</b> _____ _____</p>	
<p><b>Do you exercise regularly?</b> Y N</p> <p><b>If so, what type?</b> _____</p> <p><b>Times per week</b> _____ <b>Total number of hours per week</b> _____</p> <p><b>Where do you do your exercise?</b> _____</p>	
<p><b>Identify your stress level</b> High Moderate Low</p> <p><b>On an average, how many hours of sleep do you get?</b> _____</p> <p><b>Any personal problems in the last 12 months? (family problems, death of family members, marital problems, divorce, job change, accidents, illness)</b> _____ _____</p>	

	Good	Fair	Poor
How would you generally describe your eating habits?			
Has your appetite changed recently?		Y	N
How many times a day do you eat? _____			
How long does it take to complete a meal? _____			
Do you have trouble eating, chewing or swallowing?		Y	N
Have you ever gone on an eating binge?		Y	N
Does this still occur?		Y	N
Have you ever induced vomiting after you eat?		Y	N
Do you ever feel extremely guilty after eating?		Y	N
Do you ever find yourself preoccupied with food?		Y	N
Do you avoid foods that contain sugar or fat?		Y	N
Have you ever taken laxatives or diuretics to lose weight?		Y	N
Do you skip meals? Which meal? _____			
Where do you eat most of your meals at home?			
Do you watch TV when you eat?		Y	N
Do you clean your plate even when full?		Y	N
Do you eat standing up?		Y	N
Do you eat when preparing food or storing leftovers?		Y	N
At work, do you have the following items available? cafeteria vending machine microwave			
Do you feel that you will be able to follow a nutrition program?		Y	N
Explain _____			
Do you salt food at the table regularly?		Y	N
Do you drink coffee or tea?		Y	N
If yes, how much each day _____			
Does your weight depress you?		Y	N
Do your emotions/feelings affect your food choices?		Y	N
What are your nutrition related goals? _____ _____ _____ _____			
			Goals:

What help do you want from a registered dietitian? _____ _____ _____ _____ _____	<b>Expectations:</b>
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*To be filled out by the Client*

*For dietitian use only*

<p><b><u>For patients with Diabetes:</u></b></p> <p>Are you monitoring your blood glucose? <span style="float: right;">Y    N</span></p> <p>If yes, how many times per week: _____</p> <p>Please indicate your blood sugar readings:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 40%; text-align: center;">Time of Day</th> <th style="width: 60%; text-align: center;">Blood Glucose Reading</th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table> <p>What problems with your diabetes management are you experiencing at this time?</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	Time of Day	Blood Glucose Reading											<b>Diabetic Management:</b>
Time of Day	Blood Glucose Reading												

**Please continue to the next page for food history information.**

**Food History**

Please include records of intake for one week-day and one weekend day. Include all meals, snacks and drinks.

**Day 1**

Date	Time	Food	Amount	Meal Location

**Day 2**

Date	Time	Food	Amount	Meal Location



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## OFFICE PROCEDURES

### CONSULTATION FEES

Medical Nutrition Therapy fees begin @ \$85.00 and increase depending on amount of time, as well as complexity of medical nutritional issues. Reduced rates may be available to you and your group.

### INSURANCE

Web-RD, LLC is participating providers for the following: United Healthcare, Blue Cross/Blue Shield, Great-West/Cigna, Humana and Medicare.

With appropriate authorization/referral from your primary care physician, insurance will be filed on your behalf. All co-pays are due at the time of service. Remember your insurance benefits are a contractual agreement between you and your insurance company, Web-RD, LLC can never guarantee what you and your insurance company have contracted as your covered benefits.

**YOU, THE PATIENT, ARE RESPONSIBLE FOR FEES  
INCURRED SHOULD YOUR INSURANCE DENY  
PAYMENT.**

**I have read, understand and accept my responsibility regarding  
my insurance and payment for professional services provided to  
me.**

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Full Name

Signature

Date



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## CANCELLATION POLICY

We intentionally have a fixed and moderate patient load so that we can provide the best quality of care for you. When we have a regular scheduled appointment, that time is reserved solely for you, as if you "rented" that space. If you must cancel an appointment and do so at least 24 hours in advance, you will not be charged your deposit for your missed appointment

If you cancel less than 24 hours in advance or have repeatedly cancelled appointments, we may impose a cancellation fee.

Monies will be refunded accordingly or applied to future appointments.

These charges are not reimbursable by your insurance company. This policy is not meant to be punitive, harsh, or judgmental. It is designed only to keep our medical services viable.

Thank you for understanding our policy. Please let us know if you have questions or concerns.

**I have read, understand, and agree to this policy.**

Full Name

Signature

Date

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## RECORDS RELEASE

Please list names of physicians and/or counselors you are currently under the medical care of. Please indicate (X) if it is agreeable to you for us to contact these health care providers if necessary to discuss your medical needs/care, obtain lab work, provide written report(s) concerning your medical care.

Health Care Provider	Phone	Address/Fax	(X) Yes	(X) No

Patient/or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

## RECEIPT OF PRIVACY POLICY

I acknowledge receiving a copy to read of the Notice of Privacy Practice for Web-RD,LLC.

Patient/or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

## CONTACT PHONE NUMBERS

Please indicate at least two phone numbers we may contact you at if needed to confirm appointment, possibly change an appointment due to illness or emergency of the dietitian, i.e., work, home, cell.

Home# \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

I am agreeable to being contacted at the phone numbers listed above. Please list any privacy guidelines you would like us to specifically respect:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient/or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Next Page →



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## ASSIGNMENT OF BENEFITS

*(Please disregard this page if you are not using insurance coverage.)*

I acknowledge receipt of medical services and authorize the release of any medical information necessary to process this claim for health care payment only.

I hereby instruct and direct the \*insurance company designated below to issue direct payment to Web-RD, LLC for the medical expenses allowed under my current insurance policy. Such payment shall be applied towards the total charges for the services rendered on my behalf by Web-RD, LLC and that are invoiced to my insurance company. This assignment is a direct assignment of my rights and benefits under my insurance policy. I agree to pay to Web-RD, LLC in a current and timely manner, any balance of medical charges and expenses over and above the amount of the allowed insurance payment, including charges for any services not covered by insurance, co-pays, expenses and any deductibles that are required pursuant to the above-mentioned insurance policy.

\*Please remember it is your responsibility to determine if your insurance policy will cover the services of a registered dietitian to provide medical nutrition therapy to you.

\_\_\_\_\_  
Patient's Signature Date

\_\_\_\_\_  
Patient's Name Printed Social Security No.

\_\_\_\_\_  
Patient's Agent or Guarantor Relationship

\_\_\_\_\_  
Reason for Other Patient's Signature

Name of **Primary** Insurance Co: \_\_\_\_\_

Group Number/Policy Number: \_\_\_\_\_

Name of **Secondary** Insurance Co: \_\_\_\_\_

Group Number/Policy Number: \_\_\_\_\_